MENTALLY ILL OFFENDER
PROGRAM EVALUATION SURVEY

For purposes of this survey:

- Program refers to a defined set of interventions that will be given to a specified research sample in order to evaluate well-stated hypotheses. If you have more than one Program, please fill out a separate survey for each Program.

- Research Design refers to the procedures you will use to test the stated hypotheses for your Program. In some instances you will have more than one Research Design for a Program, in which case a separate survey must be completed for each Research Design.

- Project refers to all the work that you propose to do with the MIO Grant. For example, if you have two Programs and two Research Designs for each Program, the entire effort would constitute your Project (and you would complete four surveys).

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2. **Program Name: CROMIO**
(Community Reintegration Of Mentally Ill Offenders)

3. **Treatment Interventions**: The CROMIO Treatment Interventions are described in the narrative below.

PROPOSED PROJECT

The DMH, the LASD, and the Probation Department propose to develop an intensive community service program that will provide a continuum of case management, employment and integrative services for a population of mentally ill offenders. This sub-population will be persons who, by the nature of their contacts with the criminal justice system are likely to be sent to state prison. They must also have an Axis I diagnosis of a serious mental illness and a problem with substance abuse. In addition to the normal services of an intensive community treatment program, it will be enhanced by the following elements:

- It will begin interventions while the person is incarcerated.
- It will have built-in provisions for reduction of recidivism.
- It will target mentally ill individuals who utilize the criminal justice system disproportionately.

- It will incorporate measures to break down resistance to treatment.
- It will leverage the skills and knowledge of several public and private institutions in a collaborative effort.

Each modular program will be framed after the highly successful ACT (Assertive Community Treatment) model. Because mentally ill offenders often lack the community connections and skills necessary to navigate the various social service systems, they are unable to access the resources necessary to stop re-offending. Generally, mentally ill offenders do not feel they are a part of the mainstream community. Consequently, the Program will provide arenas in which to practice skills and abilities so those Members can confidently reintegrate, in both social life and employment, in the mainstream community. The Program will be comprised of coordinated services designed to meet the mentally ill offender's personal, social and vocational needs while ensuring public safety.

Referrals for the Program will be accepted from Jail Mental Health staff, Mental Health Court Program staff, judges, attorneys, probation officers, law enforcement personnel, community agencies and family members of persons currently in the jail. Candidates will be evaluated in jail for the above criteria and, if accepted, the "engagement" phase of the program will be started in the jail in order to begin the process of building trust and a willingness to enter the program. Once accepted, the person is referred to as a "Member" and is assigned to a Service Coordination Team (SCT), and to a Personal Service Coordinator (PSC). During the engagement phase, the PSC, along with the criminal justice liaison from the Probation Department, will educate the Member on the Program they will enter upon release from jail. At this point, an assessment of each Member will be initiated that includes what the Member's goals and needs are. The PSCs partner with the Members to achieve the Member's goals. They will accompany and guide Members as they establish entitlements, pursue education, obtain employment and engage in leisure activities. Each module will have 108 Members. The SCT is comprised of a team leader, a psychiatrist, one registered nurse, two psychiatric social workers, two probation officers, two deputy sheriffs, two substance abuse counselors and five case-managers, who may be non-licensed and may be former consumers. In addition, the Team will provide community employment and integration services through the efforts of a resource specialist, two job developers, two job coaches and a community integration specialist.

A home site, either freestanding or integrated into an existing program, will serve as the meeting place for staff and Members. It will house the Program staff and administrative offices and a drop-in center for the Members. The building assumes less importance in such a program because about 70% of staff time should be spent out with Members in the community rebuilding their lives around work and community living.

Even during the engagement phase, but more intensely following release, a more comprehensive assessment gathers information on the Member's history, needs and goals. This assessment serves as a basis to formulate an individual personal service plan.

The service plan guides the delivery of services because it details the goals of the Member and the actions necessary to accomplish these goals. Aggressive outreach, both in the community and in jail, will prevent Members from engaging in behaviors that risk re-arrest. Members will be provided transportation to essential services, such as medical and dental appointments, vocational and educational services and recreational opportunities. As Members develop the skills to meet their own needs, they will be encouraged to use public transportation.

<u>Methods of Service Delivery:</u>

Pre-Release Services

Personal Service Coordinators (PSCs) will begin to establish relationships with new Members by offering social support and preparing Members for transition into the community by engaging in pre-discharge discussions including medication issues, housing, programming and maintaining sobriety. Using the initial assessment as a guide, PSCs will arrange the housing of each Member. PSCs, together with the Deputy Sheriff assigned as liaison, will coordinate the release and transportation of each Member.

Psychiatric Care

The Service Coordination Team psychiatrist will assess and diagnose each Member and work with the Member to improve the efficacy of the medication and decrease side effects. Psychiatrists will conduct weekly support classes to educate Members in effectively managing their own medications. Registered nurses will administer medication, if needed, and the psychiatrist will assist the Member in dealing with side effects. Psychiatrists will be active members of the Service Coordination Team (SCT) and will be present at Member meetings and available on an as-needed basis. Psychiatrists will be available by beeper 24 hours a day for crisis response, including telephone contact, home visits and emergency walk-in visits. If inpatient treatment is required, the psychiatrist will manage the Member's hospital treatment and discharge. The Member's PSC will provide support throughout the hospital stay. If a Member requires a conservator, the psychiatrist will collaborate with the Office of the Public Guardian, which is the conservatorship investigator for the County of Los Angeles, as well as the primary Public Conservator. Crisis intervention will be available 24 hours per day, seven days per week, by the on-call Program staff persons.

Medical Care

All Members will receive a physical examination by a physician of the LAC+USC Medical Center residency program. Through the cooperation of the LAC+USC Medical Center, a resident physician will provide routine medical examinations and care at the program weekly.

Drug and Alcohol Rehabilitation

The Substance Abuse Specialist on each Team will provide community-based drug and alcohol rehabilitation services at the Program. These specialists will lead in-house support groups on the 12-step model, as well as assist Members in becoming involved with 12-step programs in the community. Members will attend a consumer-run Dual Diagnosis Anonymous Group weekly and will be encouraged to attend community AA meetings. The specialists will consult with PSCs in the design of personal service plans and will provide individual substance abuse counseling when needed. Drug and alcohol testing will be conducted at the program as directed by the probation officer assigned as liaison to the program.

Criminal Justice Liaison

The Probation Department will assign two full-time probation officers to carry the caseload of all the Members. The probation officer will be available to Program staff and will be a consultant to the SCTs. The probation officer will orient the Members in crime and recidivism prevention and monitor compliance with conditions of probation and report progress to the Court. The DMH Mental Health Court Program will facilitate communication with the Court system. Two full-time Deputy Sheriffs will be assigned to the Program and will be the liaison to the Sheriff's Department. The role of the deputies will vary depending on the needs of each Member and where the Member is in the referral process. The deputies will work in conjunction with Mental Health staff in referring and in selecting appropriate candidates for the Program. This process will involve making joint mental health/custody risk assessments and determining the appropriateness of clients for the Program. This is particularly important, as deputies often have valuable information related to the inmate's behavior while in custody. The deputies will act as general liaisons between the Sheriff's Department and the CROMIO program in that they will facilitate movement of clients referred to the Program, including facilitating access to the jail for the CROMIO engagement team. Deputies will be integrally involved in the Member's release from jail and, in conjunction with mental health staff, will escort the Member through the Inmate Reception Center, providing transportation of the Member to the CROMIO program. Deputies and Mental Health staff will attempt to involve the Member's support system, including the Member's Personal Service Coordinator and/or family members as appropriate, in the transitioning of the Member from jail to the community. Both the probation officers and the Deputy Sheriffs will be viewed as an integral part of the Member's treatment team and will be involved in the Member's treatment, as indicated by the treatment team. Once in the program, Sheriff's deputies and probation officers may work with Members to help them identify the legal consequences of their behavior and ramifications of inappropriate behavior. Each will establish relationships with Members built on mutual respect and trust through frequent contact and participation in activities at the Program. Their roles will strike a balance between individual rights and public safety. Members of the criminal justice system including judges, defense attorneys

and prosecutors will be invited to group discussions to explore new ways for Members to make positive changes in their relationships with the legal system.

Supported Housing

The Program will establish partnerships with homeless shelters, board and cares and residential programs to provide recently released Members with housing. Funding for Members without entitlements will come from the County's Interim Funding Program. Members whose goals include independent living will be assisted with making that transition. Personal Service Coordinators will provide one-on-one training in living skills such as budgeting, shopping, cooking, cleaning, and landlord mediation. The Personal Service Coordinator will visit the Member at his residence at least once a week to provide outreach and monitoring.

Financial Services

The Personal Service Coordinator assists Members in obtaining and maintaining benefits and entitlements. The Program will collaborate with the Social Security Administration and the Department of Public Social Services to ensure that Members receive all the benefits for which they are eligible. Members who are unable to effectively manage their money will have a money management program available to them. The DMH has an established partnership with Mental Health Advocacy Services, a nonprofit legal assistance and advocacy organization sponsored by the Los Angeles County and Beverly Hills Bar Associations. This agency will provide advocacy services for Members who have problems with obtaining benefits.

Daily Living Skills Training

Members will receive one-on-one training and classes on a variety of independent living skills. Personal Service Coordinators and Probation Department staff will provide instruction on shopping, use of public transportation, cleaning, cooking, time management, personal hygiene, budgeting, etc. Training will also be provided on understanding community resources and entitlement programs. Finally, instruction in areas such as communication skills, problem-solving skills, and assertiveness training will enhance a Member's ability to advocate for him/herself.

Employment and Community Integration Services

Because work and a productive life in the community are essential to avoiding recidivism, the employment and community integration efforts are equally important to the SCTs and all their services. Resource specialists (one per SCT) will prepare people to get jobs in the community through helping Members develop proper work attitudes, resumes, appearance, etc. Job developers (three per SCT) will be constantly in the community searching out employers who will employ the Members. Job coaches (two per SCT) will support Members in their jobs, both on an individual basis and in group sessions. Community integration specialists will be knowledgeable of community resources and will coach Members in appropriate social skills and arrange for group activities as appropriate. They will always be directed toward helping the Member gain the greatest independence and integration into the larger community.

Educational Services

Personal Service Coordinators and Probation Department staff will assist Members in enrolling in school, completing financial aid forms, scheduling classes and maintaining attendance.

Peer Support

The Program will collaborate with the Mental Health Association's Project Return program to establish peer self-help groups at the program. These consumer-run groups will provide opportunities for Member's to support each other and problem solve on common problems.

Family Involvement

Families are invited to assist in developing Member's Personal Service Plans with the Member's consent. Staff is available to meet with Members and their families. After-hour coverage is available through the program.

Training:

Initial and ongoing training of staff involved in this project is critical to the Program's success. All staff involved in this program, from support staff to psychiatrists, probation officers and Sheriff's Deputies, will participate in an initial five-day orientation to the concept and application of providing intensive case management services. The orientation will be provided by the Mental Health Association's Village ISA in Long Beach, California and will focus on all aspects of intensive case management. The orientation will also serve as a way for staff of varied disciplines and backgrounds to develop a shared understanding of the Program, its philosophy and the role each staff member plays in the Program. Ongoing training will also be incorporated and will be provided by the Village ISA and by the Departments of Mental Health, Sheriff's and Probation.

The MIOCR Strategy Committee and the Service Area Advisory Committee (SAAC) will continue to be involved in the implementation of the Program and will leverage its combined expertise and influence to ensure the Program is implemented.

4. **Research Design:**

The Program Evaluation Study incorporates a true experimental design with a slight modification which will affect a small number of subjects. It is anticipated that the vast majority of subjects will be assigned to the treatment and control groups using random assignment. We have made provisions that subjects could be directly referred to the Program by judges and probation officers. For practical and ethical reasons these individuals cannot be assigned to the control group. Data regarding these individuals will be analyzed via pre-post procedures and will be tracked via the various computer tracking systems (see Assessment Process and Outcome Variables). Between groups comparisons will be made between the True Experimental Group (those randomly assigned), the Referred Group (Courts and/or probation) and the Control Group. All subjects will be selected using the same selection criteria (see below). Inmates meeting criteria will alternately be assigned to the treatment and comparison groups. It is not anticipated that this design will result in any systematic sampling bias. The above-described between groups analyses will shed light on this assumption.

Outcome will be determined through multiple data sources/comparisons. A comparison will be made between the Control, Referral and Treatment groups on Outcome Measures (see below). Follow-up data on the Control Group will be obtained through computer databases including the MIS (Management Information System), AJIS (Automated Jail Information System), CCHRS and Los Angeles County Probation Department records. It is anticipated that we will incur some subject loss (e.g., inmate moved out of state). It is not anticipated, however, that this number will be significant.

The Treatment Group will be tracked using these same databases, but will also be assessed via a pre-post assessment methodology with repeated assessments throughout the program duration. This is addressed in the Outcome Measures Section (see below). Pre-assessment data will be obtained from Treatment Group inmates via a Biographical/Clinical data evaluation interview designed to obtain information on previous source of income, employment, housing, detailed psychiatric history and criminal history including number of police contacts, arrests, incarcerations, as well as nature (e.g., jail vs. prison) and duration of incarceration. Subject selection will be conducted through a multiple step process. First, the entire population of inmates who are assigned to mental health treatment modules in TTCF (approximately 2500) will be screened to select a subgroup of inmates who have a history of 2 or more arrests with a current felony arrest (see selection criteria). This group will be further screened by a trained mental health worker to determine primary psychiatric diagnosis (DSM-IV), presence of a co-existing substance abuse disorder and, finally, to assess residential status (homelessness or risk of homelessness). Inmates who fulfill these criteria and are assigned to the Treatment group will enter the Engagement phase of the program while still incarcerated.

Inmates assigned to the Control group will be followed via computer data bases. These individuals will receive traditional treatment and services. There will be no restriction of services, whatsoever, and their treatment and progress will be charted primarily through the Management Information System which tracks all episodes

of treatment in the L.A. County system.

4a. The checked statements below best describe the Research Design and the comparisons that will be made.

Research Design (Check One)	
X	True experimental with random assignment to treatment and comparison groups
	Quasi-experimental with matched contemporaneous groups (treatment and comparison)
	Quasi-experimental with matched historical group
	Other (Specify)
Comparisons (Check all that apply)	
	Post-Program, Single Assessment
x	Post-Program, Repeated Assessments (e.g., 6 and 12 months after program separation)
	Pre-Post Assessment with Single Post-Program Assessment
x	Pre-Post Assessment with Repeated Post-Program Assessments (e.g., 6 and 12 months after program separation)
	Other (Specify)

4b. If you are using a historical comparison group, describe how you will control for period and cohort effects. N/A

5. **Cost/Benefit Analysis**: Indicate by checking "yes" or "no" whether you will be conducting a Program cost/benefit analysis that includes at least: a) the cost per participant of providing the interventions to the treatment and comparison groups; b) the cost savings to your county represented by the effectiveness of the treatment interventions; and, c) your assessment of the program's future (e.g., it will continue as is, be changed significantly, be dropped) given the results of the cost/benefit analysis.

Cost/Benefit Analysis			
	Yes	**x**	No

5a. If you will perform a cost/benefit analysis, describe how that analysis will be performed.

6. **Target Population**:

The target population for the present study consists of individuals who have been determined to have a serious and persistent mental illness and who also have a significant history of criminally involved behavior. These are individuals who have a history of multiple arrests including a current felony arrest. Additionally, these individuals have a separate and enduring substance abuse problem (abuse or dependence). We are specifically targeting persons who have a high risk of being sentenced to state prison on the current arrest. We are presently undertaking a study to determine which mental health patients who meet Selection Criteria are most likely to be sentenced to prison. We have reviewed approximately 60 inmates from Mental Treatment Modules who have been sentenced to prison but who have not yet been transported from TTCF (charts still available). Initial data indicate that our current Selection Criteria describe this group in general. However, these data suggest that prison sentenced inmates tend to be somewhat older than the average TTCF inmate, have a longer previous criminal history, have a current drug related offense and have no identified significant other. The great majority of these individuals are either single, divorced, separated or widowed. These data may suggest some minor modifications in subject selection.

In sum, the target population is a group of inmates who have a long term significant mental illness which co-exists with an enduring problem with substance abuse/dependence. These individuals have minimal personal and community resources and are high utilizers of the criminal justice system. The target population consists of males and females who, without significant intervention will spiral down to the point to receiving long term state prison sentences.

Selection Criteria

1. Axis I (DSM-IV) diagnosis of major psychiatric disorder (excluding adjustment disorders).
2. Axis I (DSM-IV) diagnosis of coexisting substance abuse/dependence disorder.
3. Inmate is currently in treatment for mental disorder in TTCF.
4. Inmate will have a history of previous psychiatric treatment as indicated by a previous psychiatric hospitalization and/or treatment with a major psychoactive medication.
5. Inmate will have a history of at least 2 previous arrests.
6. Current arrest is a felony.
7. Male or female inmates with an age range from 18 to 60.
8. Homeless or clear risk of homelessness.

Note: As has been mentioned above, Selection Criteria may be revised or modified based on results of a recently commenced study designed to clarify the characteristics of inmates who are in mental health who pose a high risk of being sentenced to state prison. The study focuses on a sample of 200 inmates who were recently housed in Mental Health Treatment Modules in TTCF and were sentenced to state prison. Medical/jail files, as well as computer data based information will be analyzed to determine salient clinical and demographic inmate characteristics that appear to correlate with a prison sentence outcome.

6a. Describe any standardized instruments or procedures that will be used to determine eligibility for Program participation, and the eligibility criteria associated with each (e.g., "significant psychopathology" as measured by the MMPI, etc.).

No standardized instruments will be used. We are developing a biographical/clinical data sheet for purposes of pre- post-test comparisons.

7. **Sample Size**: This refers to the number of subjects who will participate in the treatment and comparison samples during the entire course of the research. As in any applied research program, subjects drop out for various reasons (e.g., moving out of the county, death). Also, some Program participants, although mentally ill as specified, may be excluded from the research sample because they do not meet the latter's criteria.

The table below provides a succinct overview of the number of participants included in the statistical hypothesis testing for evaluating the four-year Program outcomes and that are expected to complete the treatment and comparison group interventions and the six and twelve month follow-up period.

Under **Unit of Analysis**, check the box that best describes the unit of analysis you will be using in your design.

Sample Sizes (Write the expected number in each group)		
Program Year	Treatment Group	Comparison Group
First Year	108	108
Second Year	108	108
Third Year	108	108
Total	108	108

Unit of Analysis (Check one)			
X	Individual Offender		Family
	Institution		Geographic Area (e.g., neighborhood)
	Other		Other:

8. **Key Dates:**

- "Program Operational" is the date that the first treatment subject will start in the Program.
- "Final Treatment Completion" is the date when the last treatment subject in the research sample will finish the interventions that constitute the Program (and before the start of the follow-up period).
- "Final Follow Up Data" is the date when the last follow-up data will be gathered on a research subject (e.g., six months after the last subject completes the treatment interventions or whenever these data will become available).

Program Operational Date:	January 1, 2000
Final Treatment Completion Date:	June 30, 2003
Final Follow-up Data Date:	August 30, 2003

9. **Matching Criteria**: (Whether or not you are using a true experimental design), please indicate the variables that you will be tracking to assess comparability between the groups. Matching criteria might include age, gender, ethnicity, socioeconomic status, criminal history mental health diagnosis, etc.

Treatment and Control subjects will be matched on selection criteria (see above) and will also be matched on age, gender and ethnicity. Selection Criteria call for an AXIS I psychiatric diagnosis. An attempt will be made to match on the type of disorder, e.g., mood disorders vs. thought disorders. Also, subjects will be matched on the basis of chronicity and severity (GAF).

9a. After each characteristic listed above, describe how it will be measured.

Axis I mental disorder and separate substance abuse disorders will be determined from the clinical charts from inmates on their treatment modules in TTCF (see #4 above). Determination of history of psychiatric treatment and type of treatment (e.g., medication) will be obtained from the clinical chart and by additional data obtained by a project psychologist/psychiatrist. GAF will be determined in a similar fashion. Arrest history will be determined by reference to the Automated Jail Information System (AJIS), as well as other data systems including CCHRS. Level of present arrest will also be available

through these data sources. Determination of homelessness is based on the work of Stein and Gelberg (1995). Data will be obtained from chart information and data collected through MIS and other data as well as personal interview (Treatment Group).

9b. Which of these characteristics, if unequally distributed between the treatment and comparison groups, would complicate or confound the tests of your hypotheses? How will you manage that problem?

Any significant difference in Treatment-Control group's characteristics would create problems in terms of hypothesis testing and drawing general conclusions from the results. We anticipate, however, that as a result of a large population of potential subjects and random assignment such problems will bb avoided.

9c. If you are using an historical comparison group, describe how you will ensure comparability (in terms of target population and matching characteristics) between the groups.

Does not apply.

10. **Comparison Group**: The intent here is to document the kind of comparison group you will using. If you are using a true experimental design, the comparison group will be randomly selected from the same subject pool as the treatment subjects (in which case you would enter "true experimental design" in the space below). However, for quasi-experimental designs, the comparison group might come from a number of different sources such as: matched institutions, matched geographical areas, other matched counties, a matched historical group, etc.

The present design essentially uses a true experimental design as has been discussed above. We anticipate no systematic biases.

11. **Assessment Process**: The intent here is to summarize the assessment process that will determine the nature of the interventions that the mentally ill offenders in the treatment group will receive. For example, psychological testing, multi-agency and/or multi-disciplinary assessments, etc. Also, describe the qualifications of those who will be doing the assessments.

Persons in the Treatment Group will be assessed on a *real time basis* regarding employment, housing and psychiatric treatment as well as police contacts, arrests and incarcerations. Any change in these variables will be recorded on at least a weekly basis. Ongoing involvement in drug/alcohol abuse treatment will be similarly recorded. The entire treatment team (see above) will make weekly assessments. The Caminar system will be used a vehicle for data collection/entry.

11a. Describe any standardized assessment instruments that will be administered to all treatment group subjects for the purposes of identifying appropriate interventions.

None.

11b. Describe any assessment instrument designed by your county that you will use.

A biographical/clinical data sheet is being developed as a basis to assess pre-post-test differences on the Outcome Measures (see above). This will basically provide information regarding basic demographics

such as marital status, living situation, previous source of income , occupational level, psychiatric status (GAF is being operationalized) , number of days incarcerated or institutionalized, psychiatric diagnosis, previous treatment in psychiatric and substance abuse settings, etc.

11c. Identify which assessment instruments, if any, will also be administered to comparison group subjects.

Outcome data for the Control Group will be obtained by follow-up computer data based tracking including MIS, AJIS and CCHRS. No instruments will be directly administered to the Control group. The assessment process, which is still under minor modification, will be satisfactory to the Los Angeles Mentally Ill Offender Project Manager, the project research team, and the Board of Corrections staff and will be the subject of letter from the Board of Corrections upon mutual agreement.

12. T**reatment Group Eligibility**: Indicate the process (as opposed to the criteria) by which research subjects will be selected into the pool from which treatment subjects will be chosen. This process might include referral by a judge, referral by a school official, referral by a law enforcement officer, administration of a risk assessment instrument, etc.

Treatment Subjects may be referred by mental health program staff, courts, district attorney, probation and other agencies. As discussed above, it is anticipated that this will account or a small number of subjects since no concerted effort , at this time, will be made to solicit from these sources. Los Angeles County has a separate program which is able to provide similar services under less rigorous acceptance conditions. The actual process of subject selection has been discussed above under Research Design.

13. **Comparison Group Eligibility**: Indicate the process by which research subjects will be selected into the pool from which comparison subjects will be chosen. For true experimental designs, this process will be the same as for treatment subjects.

See #9 above.

13a. If procedures for determining the eligibility of participants for the Comparison Group differ from those described in 12, please describe them. If different procedures are used, how will you ensure comparability of the two groups in terms of critical characteristics?

See # 4 above

Answer questions 14 - 17 by filling in the table below as instructed.

14. **Outcome Variables**: In the table below, list some of the most important outcome variables that you are hypothesizing will be positively affected by your Program. Possibilities include improvement in personal functioning, arrest rate, successful completion of probation, alcohol and drug-related behavior, risk classification, etc.

15. **Score/Scale**: To "measure" the effects produced by your Program requires putting the variable in question on some sort of measuring scale (e.g., a test score, a count of occurrences, a rating scale, a change-score indicating progress of some sort). For each variable, for which you are making a hypothesis, indicate in the table below the measurement that you will be statistically analyzing when you test your hypothesis. As indicated in #11 above, we are undergoing minor modifications in our assessment process. The final process/procedure will be satisfactory to the Los Angeles Mentally Ill

Offender Project Manager, the project research team, and the Board of Corrections staff, and will be subject to a confirming letter from the Board of Corrections upon mutual agreement.

16. **Additional Information**: To explain more fully how you intend to test your hypothesis, you might find it helpful to supply additional information. For example, you might intend to partition the data by gender, or make differential hypotheses for different age ranges. Supplying "additional information" is optional; but if there is some aspect of the hypotheses testing that is important for us to know about, please supply the information in this section.

16a. For each outcome variable that will not be measured by a standardized assessment procedure, describe the measurement procedures that will be used. For instance, if your county has developed a risk-assessment tool that you will be using to measure change; please describe how it works.

17. **Significance Test**: In order for a statistical procedure to be the appropriate test of a particular hypothesis, certain assumptions must be met. It is critical at the outset of a research design to make sure that the measuring devices, measuring scales, samples, and methodology produce the kind of data that fit the requirements of the intended statistical procedure. In this section, please list your choice for the testing of your hypothesis, given the research design you have chosen, the measurement you will use, and the data you will be collecting.

Variable	Score/Scale	Additional Information	Significance Test
Residential stability			
Stable income			
Psychiatric treatment compliance		SEE NOTE BELOW	
Police contacts			
Arrests			
Incarcerations			
ER calls			
Psychiatric emergencies			
Substance abuse			

NOTE: Outcome Measures.

1. Residential stability is defined as safe appropriate long-term housing. This outcome measure will be broken down into sub-measures dealing with duration or stability of housing and level of independence. These data will be recorded on a *real time* basis. Independence will be assessed on a continuum ranging from very restrictive (e.g. psych hospital or IMD) through board and care facilities, other residential programs, shared housing to independent domicile.

2. Stable source of income is defined as employment or other stable sources of economic support (e.g., SSI). Employment will be rated in terms of degree of gainful employment and job level. Degree of gainful employment will be rated on a continuum ranging from volunteer work through in-house work to part-time work and, finally, to full-time work. Employment will also be rated in terms of duration, as well as level or quality of job (menial through skilled through managerial, professional etc.)

3.Consistent, regular psychiatric treatment. This is defined as remaining in treatment, making and keeping appointments, taking medication if prescribed, etc. It is anticipated that regular treatment would be associated with symptom reduction which would be independently assessed through medical records and progress reports.

4. Decreased police contacts/citations. (Compared to previous baseline.)

5. Decreased arrests (compared to previous baseline, anticipated net reduction 50%).

6. Decreased incarcerations (compared to previous baseline, anticipated net reduction 50%).

7. Decreased emergency calls (911, SMART/MET, PMRT, etc.).

8. Decrease in number of psychiatric hospitalizations and emergency visits. This could be amended as a function of time post jail release. For example, hospitalization soon after release could be construed as positive as an alternative to more maladaptive behavior that could lead to contact with the criminal justice system. However, later use of such emergency services would relate to instability.

9. Decreased substance abuse.

As indicated above, outcome measures will be assessed using several criteria. A pre (baseline) to post measure will be assessed as indicated above. Other outcomes such as income, stability of psychiatric treatment and housing will be measured on an ongoing *real time* basis. Specific procedures for recording these data are being developed.

A number of different statistical analyses/procedures will be used to determine the efficacy of treatment interventions. The specific statistical analysis used with each outcome variable will be determined as a function of scaling and the nature of the variable. For example, employment and housing can be broken down into ordinal data by numerical data assignment for categorical data (e.g., for the continuum of unemployed, partially employed, full-time employed, etc., would receive numerical assignment of 1, 2, 3, etc.). This would allow for the use of standard statistics such as ANOVA with repeated measures over time for the Treatment Group. The time effect will be assessed by appropriate data entry on a monthly basis.

Pre-Post- test differences (for ordinal data) will also be analyzed via Analysis of Variance. For Nominal dichotomous data (e.g., recidivism vs. no recidivism) a non-parametric statistic (X^2) will be used. This method will be used, for example, if comparing nominal data on post test comparisons between the Treatment and Comparison groups.

The following questions are supplemental to the Research Design Summary Form and will help us understand how you intend to manage data collected for this project.

18. What additional background information (if any) will be collected for the participants (both treatment and comparison)? For instance, will you gather information about family criminal background, drug involvement, family variables, work history, educational background, etc. If so, what will be collected and how?

The biographical/clinical data sheet/interview process is under development.

19. How will the process evaluation be performed? What components will be addressed and how will they be measured (e.g., services available and frequency of use of those services by each participant)? What is the time frame for gathering process-related information? What recording mechanisms will be used? If descriptive or statistical analyses will be performed, please describe what they will be.

Each modular program will keep its own data on subject participation and progress. This will include data on attendance in psychiatric treatment, counseling, drug/alcohol treatment sessions and classes. The case manager will record data on all Outcome Variables (see #'s14 through 17) on an ongoing basis. Process evaluation is integral with outcome evaluation. These data will be collected on a real time basis recording all services, sessions, numbers and frequency. These data will be recorded on MIS (when appropriate) and the CAMINAR system will be used for real time recording and analysis. For statistical analysis see #17.

20. Describe how you will document services received by the treatment and comparison group members. Examples are: how many counseling sessions did the subject attend, how intense (and by what measure) was the drug treatment, did the subject complete the interventions, etc.?

The Control Group will receive whatever treatment services are available in the community that they apprise themselves of. This will be tracked by computer databases (see #4). Services for the Treatment Group will be documented as described above (#19).

21. What will be the criteria for completion of the program (by what criteria will you decide that the research subject has received the full measure of the treatment that is hypothesized to have a beneficial impact. For instance, will the Program run for a specified amount of time irrespective of the participants' improvement or lack thereof? If so, how long? Alternatively, will completion be determined by the participants' having achieved a particular outcome? If so, what will that outcome be and how will it be measured? An example is decreased risk as measured by a "level of functioning" instrument.

This program is designed to provide services to seriously and chronically disturbed mentally ill inmates. Thus, for the majority of these inmates, a formal, specific completion date would be arbitrary, artificial and unrealistic. The goal of the project is for a complete reintegration into normal life in the community with independence and a concomitant freedom from the criminal justice system. It is anticipated that these patients will require essentially life-long psychiatric and supportive services. It is further anticipated that these individuals will experience some degree of stability and a decrease in intensity of needed services. For statistical/experimental purposes, data will be analyzed at regular intervals (e.g., 6 months, one year, and two years) to evaluate the effectiveness of the various modular components to the project.

22. If Program completion will be linked to probation terms, how will you record those terms and identify adequate completion? Examples include completion of mental health or substance abuse programs, etc.

While probation is not a necessary component of the project, it is anticipated that many Members will, nevertheless, be on probation. The probation officer who acts as a team member will monitor compliance with conditions of probation and render reports of progress to the Court. Data relative to progress, in general, will be recorded as described above. Probation related data will be similarly recorded.

23. On what basis will a subject be terminated from the Program and be deemed to have failed to complete the Program? Will those who leave, drop out, fail, or are terminated from the Program be tracked in terms of the research dependent variables? For how long?

Repeated lack of cooperation and resistance to the program will ultimately lead to termination. However, with persistently and severely mentally ill patients/inmates, we do anticipate intermittent setbacks or relapses. This is precisely what the problem this program is designed to address. The Treatment Team

will continue to provide ongoing intensive case management and until the Member essentially deselects by persistent absence, significant re-offending (frequency or severity) or long term removal from the community by the legal system. If a member “deselects”, that individual will continue to be tracked via computer data bases (see above) on outcome criteria. Persons who re-offend and are resultantly re-incarcerated will be re-entered into the program if the duration of incarceration is not prohibitive (i.e., insufficient time for practical renewal of services).

/MPM
10/30/99